(159) + Death 04931

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No. 100

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. **PLACE OF BIRTH:**
   County: Charles
   City or town: La Plata
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution:
   Length of mother's stay in County:
   (How many years or months, or days. SPECIFY WHICH)

2. **USUAL RESIDENCE OF MOTHER:**
   State: Maryland
   County: Charles
   City or town: La Plata
   (If outside city or town limits, write RURAL and give nearest town)
   Street No.
   (If RURAL give LOCATION)

3. Name of child: James Ball
4. Date of birth: May 5 1948 Hour 9:25 P.M.
5. Sex: Male | 6. Twin or triplet: Twin
7. No. of weeks pregnancy: 20 wks

FATHER OF CHILD

8. Full name: James Mason
9. Color: Negro 10. Age at time of this birth: 18 yrs.
11. Usual occupation: Laborer

MOTHER OF CHILD

12. Full maiden name: Josephine Ball
13. Color: Negro 14. Age at time of this birth: 18 yrs.
15. Usual occupation: Housework

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
    (b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? No During labor? No
18. Pregnancy, complications of: Infections Hepatitis
19. Labor: (a) Complications of: None (b) Induced? No
20. (a) Was there an operation for delivery? No (Yes or No)
    (b) State all operations, if any
    (c) Did child die before operation?
    During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes: Prematurity — Cause Unknown
    (b) Maternal causes: None

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
    Signature: John L. MacKavanagh M.D.
    (Specify if M. D., midwife, or other)
    Address: La Plata Md

23. (a) Burial (Burial, cremation or removal) (b) Date thereof 5-6-48 (month) (day) (year)
    (c) Cemetery or crematory: Sacred Heart
24. (a) Funeral director: Willis Ball, Undertaker
    (b) Address: La Plata, Md

25. (a) 5-6-48 (Date rec'd by registrar) (b) Julia H. Posey (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    Health Officer, per

* See Instruction C on stub.

Child lived 40 minutes

V.S. A10

159 + Death 04932

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No. 100

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. **PLACE OF BIRTH:**
   County: Charles
   City or town: La Plata
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution:
   Length of mother's stay in County:
   (How many years, or months, or days. SPECIFY WHICH)

2. **USUAL RESIDENCE OF MOTHER:**
   State: Maryland
   County: Charles
   City or town: La Plata
   (If outside city or town limits, write RURAL and give nearest town)
   Street No.:
   (If RURAL give LOCATION)

3. Name of child: Richard Bell
4. Date of birth: May 5 1948 Hour 9:28 P. M.
5. Sex: Male | 6. Twin or triplet: Twin
7. No. of weeks pregnancy: 20 wks

FATHER OF CHILD

8. Full name: Garner Mason
9. Color: Negro 10. Age at time of this birth: 18 yrs.
11. Usual occupation: Laborer

MOTHER OF CHILD

12. Full maiden name: Josephine Bell
13. Color: Negro 14. Age at time of this birth: 18 yrs.
15. Usual occupation: Housework

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
    (b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? No During labor? No
18. Pregnancy, complications of: Hyperemesis Gravidarum
19. Labor: (a) Complications of: None (b) Induced? No
20. (a) Was there an operation for delivery? No (Yes or No)
    (b) State all operations, if any:
    (c) Did child die before operation?
    During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes: Prematurity - cause unknown
    (b) Maternal causes: None

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
    Signature: Jas R. Mackenzie M.D.
    (Specify if M. D., midwife, or other)
    Address: La Plata

23. (a) Burial (Burial, cremation or removal) (b) Date thereof 5-6-48 (month) (day) (year)
    (c) Cemetery or crematory: Sacred Heart, La Plata
24. (a) Funeral director: Willie Bell Jr. father
    (b) Address: La Plata, Md.

25. (a) 5-6-48 (Date rec'd by registrar) (b) Julia H. Posey (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    Health Officer, per

* See Instruction C on stub.

V. S. A10

Child lived 10 minutes

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04933

183

CERTIFICATE OF DEATH

Reg. Diat. No. 105

1. PLACE OF DEATH:

County: Charles

City or town: Benedict
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since birth

Hospital, Institution, or street address where death occurred:
Patuxent River

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Prince Georges

City or town: Oxon Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5560 Oxon Hill, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: World war II

3.(a) FULL NAME Charles ELROY Batch

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) June 6th 1921

8. AGE:

Years	Months	Days	If less than one day
26	11		... hrs. ... min.

9. Birthplace: Washington, DC
(Town, county and state)

10. Usual occupation: Clerk

11. Industry or business: Navy dept U.S. Govt.

FATHER
12. Name: Joseph J. Batch
13. Birthplace: Chicago, Ill.

MOTHER
14. Maiden name: Edna L. Weissman
15. Birthplace: Branchville Md.

16. Mrs. Edna L. Batch
Address 5560 Oxon Hill Rd SE Wash 20 DC

17. (Burial, cremation, or removal? Which?) Burial Date thereof 5-19-48 (month) (day) (year)
Cemetery or crematory: Arlington Natl.
Location: Arlington Va

18. Funeral director: W. W. Chapman Co.
Address 517-11th St SE. Wash. D.C.

19. 5-16 1948 (Date rec'd by registrar) M. L. Mower Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15, 1948, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1948 to ... 19... and that I last saw him alive on May 16, 1948

Immediate cause of death: Accidental drowning — DURATION: Minutes

Due to: —

Due to: —

Other conditions: Traumatic amputation left leg — DURATION: Minutes
(Include pregnancy within 3 months of death)

Major findings of operations: —

... Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 5-15-48

Where did injury occur? Benedict (City or town), Charles (County), Md. (State)

Injured at home, farm, industry, public place (where?) Patuxent River

Means of injury: Knocked out of boat Injured at work? No

23. SIGNATURE: James L. Mackarangh M.D. Deputy Medical Examiner
M. D. or other

Address: La Plata Md. Date signed 5-16-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04934

462

105

Reg. Diat. No.

1. PLACE OF DEATH:
County: Charles
City or town: Patuxent City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred: Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Patuxent City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: William Seabright Cooke

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Sarah Locks Cook
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): ? ? 1890

8. AGE: Years: 58 Months: ? Days: ? If less than one day: hrs. min.

9. Birthplace: Patuxent City, Charles, Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: Jack Cook
13. Birthplace: Gallant Green, Md.

MOTHER
14. Maiden name: Emma Ross
15. Birthplace: Woodville, Md.

16. Informant: Rose Cook Harper, sister
Address: Bryantown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-15-48 (month) (day) (year)
Cemetery or crematory: St Philips
Location: Aquasco Md
18. Funeral director: H. Dent Hayes
Address: Waldorf Md

19. 5/13 (Date rec'd by registrar) 19 48 M L Monroe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 19 48 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 47 to May 19 48
and that I last saw him alive on May 3 19 48

Immediate cause of death	DURATION
CARDIO VASCULAR COLLAPSE	
Due to [CARCINOMATOSIS GENERALIZED]	
Due to Original site "Intestinal Carcinoma"	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Generalized carcinomatosis Date of op. April 1948
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Alfred R. Lapen, MD M. D. or other
Address: Aquasco Md. Date signed May 13, 1948

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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04935

CERTIFICATE OF DEATH

Reg. Dist. No. 10-5

1. PLACE OF DEATH: County Charles

City or town La Plata md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Charles

City or town Spring Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Archie Galbreath

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Rena

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 15-1905

8. AGE: Years	Months	Days	If less than one day
42			..... hrs. ..... min.

9. Birthplace Chas Co Md

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER — 12. Name Townley Galbreath

13. Birthplace St Mary Co Md

MOTHER — 14. Maiden name Elizabeth Welch

15. Birthplace St mary Co Md

16. Informant Rena Galbreath

Address Spring Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-5-48 (month) (day) (year)

Cemetery or crematory St Ignatious

Location Bel Alton Md

18. Funeral director Hunt & Pyon

Address Waldorf Md

19. 5-4 1948 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-3 1948, at 6 H M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-12 1948, to 5-3 1948

and that I last saw h... alive on 5-2 1948

	DURATION
Immediate cause of death: Ruptured aortic aneurysm (Non-syphilitic)	5-3-48
Due to: Hypertensive heart disease	?
Due to:	
Other conditions: Cirrhosis of liver	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr Edelen M.D. M. D. or other

Address La Plata Md. Date signed 5-4-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04936

166

CERTIFICATE OF DEATH

Reg. Diat. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: Rural mr. La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? En route

Hospital, Institution, or street address where death occurred: En route to Physicians Memorial Hospital

How long in hospital or Institution? D.O.A.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Waldorf

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Henry Greenfield

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 26, 1927

8. AGE:

Years	Months	Days	If less than one day
21	0	15	..... hrs. ..... min.

9. Birthplace: Waldorf Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Mc Kinley Greenfield

FATHER — 13. Birthplace: Malcolm, Md.

MOTHER — 14. Maiden name: Elsie Greenfield

MOTHER — 15. Birthplace: Waldorf Md.

16. Informant: Elsie [illegible] Greenfield

Address: Waldorf, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-14-48 (month) (day) (year)

Cemetery or crematory: St. Peters

Location: Waldorf, Md.

18. Funeral director: Hewett & Ryon

Address: Waldorf, Md.

19. 5-12 1948 (Date rec'd by registrar) Julia A. Penn, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11, 1948, at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ~~from~~ ..... ~~19....~~ on May 11, 1948, to ~~19....~~ and that I ~~last~~ saw h... ~~alive~~ on May 11, 1948

Immediate cause of death	DURATION
Intra-abdominal hemorrhage	1½ hrs.
Due to: Gunshot wound of ~~abdomen~~ Chest	1½ hrs.
Due to: Homicide	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of 5-11-48

Where did injury occur? m... La Plata, Charles, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Shotgun Injured at work? NO

23. SIGNATURE: Deputy Medical Examiner James L. MacKenzie, M.D. M. D. or other

Address: La Plata, Md. Date signed 5-11-48

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

51b

04937

CERTIFICATE OF DEATH

Reg. Diat. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Louis Metcalf Hyde

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Elizabeth L. Hyde
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1864

8. AGE: Years: 83 | Months: 7 | Days: 7 | If less than one day: hrs. min.

9. Birthplace: Anne Arundel Co., Md
(Town, county, and state)

10. Usual occupation: Printer

11. Industry or business: Newspaper

FATHER
12. Name: John L. E. Hyde
13. Birthplace: Anne Arundel Co, Md.

MOTHER
14. Maiden name: Harriet Annie Metcalf
15. Birthplace: Annapolis Co, Md

16. Informant: Mrs. Julia H. Posey
Address: La Plata, Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 5/31/48
(month) (day) (year)
Cemetery or crematory: St. Ignatius
Location: Bel Alton, Md.

18. Funeral director: Hunt & Ryon
Address: Waldorf, Md.

19. 5-30 1948 Julia H. Posey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-29 1948 at 8 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-6 1945 to 5-29 1948 and that I last saw h[illegible] alive on 5-29 1948

	DURATION
Immediate cause of death: Multiple Thrombi	
Pulmonary Embolism	5-28-48
Mesenteric "	
Due to: Ca Prostate	3-10-48
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. Edelen M. D.
M. D. or other
Address: La Plata Md Date signed: 5-30-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

04938

105

CERTIFICATE OF DEATH

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Charles

County

City or town: Waldorf md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Charles

City or town: Waldorf Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ernest Thomas Jarboe

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mary

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 14 - 1871

8. AGE:

Years	Months	Days	If less than one day
77			hrs. min.

9. Birthplace: St Mary Co Md

(Town, county, and state)

10. Usual occupation: Ret Store Merchant

11. Industry or business

FATHER 12. Name: John Thomas Jarboe

FATHER 13. Birthplace: St Marys Co Md

MOTHER 14. Maiden name: Jane E Stone

MOTHER 15. Birthplace: St Marys Co Md

16. Informant: Bernard Jarboe

Address: Waldorf Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-12-48 (month) (day) (year)

Cemetery or crematory: St Johns

Location: Hillcrest Md

18. Funeral director: Hunt & Ryon

Address: Waldorf Md

19. 5-11 19 48 M L Moore

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May - 10 1948, at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 12 to May - 10 1948

and that I last saw him alive on May - 09 1948

Immediate cause of death	DURATION
Myocardial	
Decompensation	
Due to Cardio - Vascular	
Renal Disease	
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Ernest D. Weaver M.D.

M. D. or other

Address: Waldorf, Md Date signed 5/10/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

157 m

04939

Reg. Dist. No. 106

1. PLACE OF DEATH:
County: Charles County
City or town: Waldorf
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: Waldorf
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MADISON MARK GUY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	BLK	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): APRIL 11, 1946

8. AGE:

Years	Months	Days	If less than one day
2	0	23	hrs. ... min.

9. Birthplace: Baltimore, Anne Arundel Md.
(Town, county, and state)
10. Usual occupation: Baby
11. Industry or business
FATHER 12. Name: Walter Brown Madison
13. Birthplace: Anderson, South Carolina
MOTHER 14. Maiden name: Katie Newman Madison
15. Birthplace: La Plata, Md.
16. Informant: Katie Madison - Mother
Address: La Plata, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10 1948 (month) (day) (year)
Cemetery or crematory: St. Mary's
Location: Bryantown, Md
18. Funeral director: By family
Address: Waldorf Md
19. 5/8 19 48 M. L. Mouser
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 19 48 at 8 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 48 to May 19 48
and that I last saw him alive on March 1948 19
Immediate cause of death: Marasmus — DURATION
Due to: Malformation at birth
Due to:
Other conditions: Congenitally deformed
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Alfred R Lapey, M.D. or other
Address: Nanjemoy Md Date signed: May 8, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for change of age shown on

04940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1948

FILE NO. G 116 JUN - 3 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:
County: Charles
City or town: La Plata, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Rock Point,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Michael McNulty

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Thelma McNulty
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): JAN. 30, 1905
8. AGE: Years: 43 Months: 2 Days: If less than one day: hrs. mins.
9. Birthplace: Philadelphia, Penn (Town, county, and state)
10. Usual occupation: Dental Tech
11. Industry or business:

FATHER
12. Name: Michael McNulty
13. Birthplace: England

MOTHER
14. Maiden name: Marie Lally
15. Birthplace: Philadelphia, Penn.

16. Informant: Mrs Thelma McNulty
Address: Rock Point, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/24/48 (month) (day) (year)
Cemetery or crematory: Holy Sepulchre
Location: Philadelphia, Pa.

18. Funeral director: Hewitt & Lyon
Address: Waldorf, Md.

19. 5/22 1948 W R Simmons Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 May 1948 at 4:50 P.M. EST

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1948 to 22 May 1948 and that I last saw him alive on 22 May 1948

	DURATION
Immediate cause of death: hemmorrhage from rectum.	
Due to: Carcinoma of liver	3 years.
Due to: Portal obstruction	2 wks.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op.

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE: A R Woods, MD. M. D. or other
Address: La Plata, Md. Date signed 22 May 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04941

131a

CERTIFICATE OF DEATH

Reg. Diat. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above piece of deeth? 23 days.

Hospital, inetitution, or etreet eddress where deeth occurred: Physicians Memorial Hospital

How long in hoepiiel or inetitution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Stete: Maryland County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, neme war

3. (a) FULL NAME: Maurice W. Michael

3. (b) Social Security Number:

4. Sex	5. Celer or rece	6.(a) Single, merried, widowed, or divorced
M.	W.	W.

6.(b) Neme of hueband or wife: Mary E. Michael

6.(c) If elive, give age ..... yeers

7. Birth dete of deceeeed (mo., dey, yr.): June 11, 1866

8. AGE: Yeere 82 | Monthe | Deye | If leee then one day ..... hre. ..... min.

9. Birthpiece: Frederick Co. Maryland (Town, county, and etate)

10. Ueual occupeiion: Carpenter, Retired

11. Indeetry or buelneee

FATHER 12. Neme

13. Birthpiece Unknown

MOTHER 14. Meiden neme

15. Birthpiece

16. Informant: Maurice Michael

Addreee La Plata Md.

17. Burial (Burial, cremation, or removal. Which?) Dete thereof 5-14-48 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Locelion: Suitland, Md.

18. Funerel director: Wm. J. Malloy

Addreee 3200-R.I. Ave. Mt Rainier md.

19. 5-12 1948 (Data rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1948 at 7 45 P.M. EST

21. I CERTIFY that death occurred on the date above etated; that I attended deceeeed from 5-10 1947 to 5-12 1948 and thet I laet saw h... alive on 5-11 1948

	DURATION
Immediate cause of death: Uremia	5-1-48
Due to: Nephritis	7-10-47
Due to: Gen. Arteriosclerosis	
Other conditions	

(Include pregnancy wlthin 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause tn which death should be charged statistically.

22. VIOLENCE: If death was due to external ceuses, fill in the following:

Accident, euicide, or homicide ..... Dete of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, ferm, industry, public place (where?) .....

Meene of injury ..... Injured at work?

23. SIGNATURE: E. Edelen M.D. M. D. or other

Addreee La Plata Md. Date signed 5-12-48.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1948
1582
66

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1310 04942

Reg. Diat. No. 102-

1. PLACE OF DEATH:

County: Charles

City or town: Riverside

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Henry Posey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	CR	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) October 23 1876

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
71	7	6		

9. Birthplace: Montgomery Md.

(Town, county and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Pierce Posey

13. Birthplace: Grayton, Md.

MOTHER 14. Maiden name: Maude Hall

15. Birthplace: Alexandria Va.

16. Informant: Timothy R. Posey

Address: Riverside Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31 1948 (month) (day) (year)

Cemetery or crematory: Baptist

Location: Mahanoy, Md.

18. Funeral director: Hunter & Bijon

Address: Waldorf Md

19. May 31 1948 (Date rec'd by registrar) C. Brent Simpson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1948, at 5:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1948, to May 29 1948

and that I last saw h... alive on May 29 1948

Immediate cause of death	DURATION
Cardio-renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. C. Bicknell M.D., M. D. or other

Address Marbury Md Date signed May 31 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04943

73a

125

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Hyattsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since Apr 5/48

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: [illegible] County: [illegible]

City or town: Washington D.C. (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1315 10th St N.W. (If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American

3.(a) FULL NAME: James C Rutherford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.): March 25/85

7.(c) If alive, give age ..... years

8. AGE:

Years	Months	Days	If less than one day
63	1	15	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business: Painting House

FATHER

12. Name: [illegible]

13. Birthplace: Maryland

MOTHER

14. Maiden name: Catterson

15. Birthplace: Maryland

16. Informant: [illegible]

Address: Mrs. Martha R. Jones

17. Burial, cremation, or removal: Interred Date thereof: 5/11/48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Va.

19. Funeral director: W. W. Chamberlain & Co

Address: 573 Mass Ave N.W. Wash D.C.

19. 5/9/48 (Date rec'd by registrar) M. L. Mowatt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 19 48 at 1:4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 19 48 to May 9 19 48

and that I last saw h[illegible] alive on [illegible] 19.....

Immediate cause of death	DURATION
Pneumonia Lobar	4 D.
Due to	
Due to Uremia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: F D Chapple M. D. or other

Address: Hyattsville Md Date signed .....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

04944

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 min.

Hospital, institution, or street address where death occurred:

Physicians Memorial Hospital

How long in hospital or institution? 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Waldorf

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ruth May Shorter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 4, 1947

8. AGE: Years: 0 | Months: 6 | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Waldorf, Charles, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: George T. Butler

FATHER — 13. Birthplace: Chas. Co, Md

MOTHER — 14. Maiden name: Ella L. Shorter

MOTHER — 15. Birthplace: Chas. Co, Md.

16. Informant: Sylvester Shorter (Landlord)

Address: Waldorf, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-9-48 (month) (day) (year)

Cemetery or crematory: St Joseph

Location: Cowsett Md

18. Funeral director: Hamett & Chapman

Address: Waldorf Md

19. May 9 19.48 (Date rec'd by registrar) Mrs. Jeremiah T. Mudd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 1948, at 6.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... to ..... 19..

and that I last saw h.. alive on May 9, 1948

Immediate cause of death: Fracture base of skull — DURATION: 45'

Due to: Accidental fall

Due to: Fell out of bed

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 5-9-48

Where did injury occur? Waldorf (City or town), Charles (County), Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of Injury: Fell out of bed Injured at work? No

23. SIGNATURE: James L. MacNamara, M.D. Deputy Medical Examiner

M. D. or other

Address: La Plata, Md. Date signed 5-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170C

64945

Reg. Diat. No. 105

1. PLACE OF DEATH:

County: Charles

City or town: Waldorf
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
U.S. Highway 301

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Waldorf
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: James Thornton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	married

6.(b) Name of husband or wife: BEATRICE THORNTON

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1914

8. AGE: Years: 34 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Upper Marlboro Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: James Thornton Sr.

13. Birthplace: Prince Geo Co Md

MOTHER — 14. Maiden name: Annie Rawlins

15. Birthplace: Prince Geo Co Md

16. Informant: Beatrice Thornton Wife

Address: Waldorf Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-1-48 (month) (day) (year)

Cemetery or crematory: Zion Rosary

Location: Waldorf Md

18. Funeral director: Hewitt & Robinson

Address: Waldorf Md

19. 6-1 (Date rec'd by registrar) 1948 M L Mudd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28, 1948 at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on May 28, 1948, to 19.. and that I last saw him alive on May 26, 1948

Immediate cause of death	DURATION
Crushed Chest	Minutes
Due to: auto accident	Minutes
Due to:	
Other conditions: Possible cerebral injury	Minutes

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 5-28-48

Where did injury occur? Waldorf (City or town) Charles (County) Md (State)

Injured at home, farm, industry, public place (where?): Public place

Means of injury: Hit by truck Injured at work? No

23. SIGNATURE: James L. MacKavanagh, M.D. Deputy Medical Examiner
M.D. or other

Address: La Plata, Md Date signed: 5-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M